CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2011 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155479	B. WIN			02/10/2011
KINGSTO	PROVIDER OR SUPPLIER	OF FORT WAYNE		1010 W	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON CENTER ROA WAYNE, IN46825	D .
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for State Licensure S	r a Recertification and Survey. Survey	F00		Enclosed is the plan of correct for the annual survey complete at Kingston Care Center on 2-10-2011. Please consider the facility's credible allegation compliance. However, submission of this response at the plan of correction is not a legal admission that a deficient exists or that this Statement of Deficiency was correctly rendered, and is also not to be constructed as an admission cinterest against the facility, the administrator or any employee agent, or other individuals who draft or may be discussed in the response and plan of correction in addition, preparation and submission of this plan of correction does not constitute admission or agreement of any kind by the facility of the truth any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Rather, this plot of correction has been prepare because the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them. Kingstonwould like to	DATE ion ed nis n of nd cy s s f s s n o nis n o o o o o o o o o o o o o o o o o o
		es also reflect state accordance with 410 IAC			request a desk review a these deficiencies have been corrected prior to	
	Quality review co 2011 by Bev Fau	ompleted on February 11, ilkner, RN			the completion of the survey process.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

4VNL11

Facility ID:

000522

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155479			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2011	
		130473	B. WING	ADDRESS, CITY, STATE, ZIP CODE	02/10/2011	
NAME OF I	PROVIDER OR SUPPLIER	l .		/ WASHINGTON CENTER ROA	AD	
		OF FORT WAYNE	FORT \	WAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155479	B. WING			02/10/20	011
			D. WIII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				WASHINGTON CENTER ROA	n	
KINGSTO	ON CARE CENTER	OF FORT WAYNE			WAYNE, IN46825	.D	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0282	Based on observa	ation, interview and	F02	82	Resident #66 oxygen order ha	s	03/11/2011
	record review, th	e facility failed to assure			been clarified and is being		
	oxygen was adm	inistered at the litre flow			administered as ordered as of 2/8/2011. Residents receiving		
		nysician for 1 of 5			oxygen have been audited and		
	residents reviewe	-			verified administration as	1	
					ordered. Licensed nursing sta	ıff	
	administration in a total sample of 24. (Resident #66)				will be educated on Oxygen		
	(Resident #66) The facility also foiled to administer				administration policy and		
	The facility also failed to administer				procedure and following		
	medications in the dosage ordered for 1 of 23 residents reviewed for psychotropic medications in a total sample of 24. (Resident #53) The facility further failed to obtain labs				physician's orders by March 1	1,	
					2011. Random audits will be completed to check oxygen		
					administration daily for 7 days.		
					weekly for 3 months and mont		
					for 3 months by the Clinical		
		ered for 2 of 15 residents			Directors and/or designee.		
		and x-ray results in a			Results from audits will be		
	total sample of 2	•			corrected and educated as		
	•	4.(Resident #33,			needed with results brought		
	Resident #41)				monthly to facility Continuous Quality Improvement meeting.		
					Resident #53 medication has		
	Findings include	•			been audited and is receiving	the	
					correct dose of medication.		
	1. Resident #66's	clinical record was			Controlled medications will be		
	reviewed on 2/7/	2011 at 11:45 a.m.			audited to verify current		
	Resident #66's di	agnoses included but			medication order matches curr		
		to high blood pressure,			supply and narcotic count shee Licensed nursing staff will be	et.	
	depression and d	•			educated on medication		
	acpression and d	omonuu.			administration, documentation		
	A mhrminianta and	lam datad 2/8/2011			and drug disposition of control		
		ler, dated 2/8/2011,			substances policy and		
		nt #66 was to have			procedures by March 11, 2011		
		ered at 2 litres per minute			Random audits of administration	on	
	continuously.				and documentation will be		
					completed weekly for 1 month every two weeks for 2 months		
	On 2/9/2011 at 9	:20 a.m., Resident #66			and monthly for 3 months by the		
		ting in her wheelchair			Clinical Directors, and/or		
		Č					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155479	A. BUI	LDING		02/10/2	
		199479	B. WIN			02/10/2	011
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	_	
KINCST	ON CADE CENTED	OF FORT WAYNE		1	/ WASHINGTON CENTER ROA WAYNE, IN46825	.D	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG			DATE
	1	at 1.5 litres per minute via			designee. Results from audits will be reviewed and education		
	oxygen concentrator.				done as needed with results	•	
	On 2/9/2011 at 2:25 p.m., Resident #66 was observed resting in bed with oxygen				brought monthly to facility		
					Continuous Quality Improvement		
					meeting. Residents #55 has h	nad	
	on concentrator	at 1.5 litres per minute.			a chest x-ray completed on		
	on concentrator at 1.5 litres per limitate.				2/5/2011. Resident #41 has hat follow up lab tests completed of		
	On 2/10/2011 at	9:27 a.m., Resident #66			2/8/2011 with no new orders.	···	
	was observed sit	ting up in her wheelchair			Residents with laboratory and	l/or	
		at 1.5 litres per minute via			diagnostic orders have been		
oxygen concentrator.					audited for follow through of		
					physician orders. Licensed	on .	
	In an interview of	on 2/10/2011 at 0:24 a m			nursing staff will be educated a laboratory and diagnostic police		
	In an interview on 2/10/2011 at 9:34 a.m., Licensed Practical Nurse (LPN) #3				and procedures by March 11,	, y	
		, ,			2011. Random audits of		
		nt #66's oxygen should			laboratory and diagnostic		
	have been on at	1.5 litres per minute.			physician's orders will be		
					completed daily for 1 month,		
		on 2/10/2011 at 3:30 p.m.,			every two weeks for 2 months and monthly for 3 months by the	ne	
	the Director of N	Jursing indicated there			Clinical Directors and/or		
	was no specific p	policy regarding			designee. Results from audits	;	
	following physic	cian's orders, however it			will be corrected and educated	l as	
	was understood j	physician's orders were to			needed with results brought		
	be followed.				monthly to facility Continuous Quality Improvement meeting.		
					FACILITY NAME: Kingston Ca	are	
	2. Resident #53's	s record was reviewed on			Center of Fort Wayne POLICY		
		a.m. Resident #53's			To assure resident's receiving		
		led but were not limited			oxygen therapy are monitored		
	"	essure, diabetes, and			effectiveness of treatment and	/or	
	depression.	Toome, amoved, and			need for changes in treatment. PROCEDURE: 1.		
	dopiession.				Residents on oxygen will have	,	
	A physician's are	dar for Ambian 5			oxygen saturation levels		
	1 ^ -	der for Ambien 5			monitored every shift and as		
	1 .	vevening was received on			needed for signs and sympton	าร	
	3/17/2010.				of respiratory distress. 2.		
	<u> </u>						

A narcotic reconciliation record, dated 12/22/2010, indicated the Ambien supplied to the facility was 10 milligrams. The record indicated Ambien 10 milligrams had been administered on the following dates: December 26, 27, 28, 29, 30, and 31; January 1, 2, 3, and 4. The record indicated half of the Ambien 10 milligram tablet had been wasted on 1/4/2011. A drug disposition record, dated 1/4/2011, indicated half a tablet of Ambien 10 milligrams had been wasted. In a confidential interview on 2/9/2011 at 1:50 p.m., a nurse indicated the whole tablet of Ambien 10 milligrams had been given. The tablet had not been cut in half nor any part of the Ambien 10 milligrams of the whole tablet and given only 5 milligrams of the	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
SWING STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE INd6825 WASHINGTON CENTER ROAD FORT WAYNE, INd6825 WASHINGTON CENTER ROAD COMPLETION COM	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING		COMPL	ETED
NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE IN SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A narcotic reconciliation record, dated 12/22/2010, indicated the Ambien supplied to the facility was 10 milligrams. The record indicated Ambien 10 milligrams had been administered on the following dates: December 26, 27, 28, 29, 30, and 31; January 1, 2, 3, and 4. The record indicated half of the Ambien 10 milligram tablet had been wasted on 1/4/2011. A drug disposition record, dated 1/4/2011, indicated half a tablet of Ambien 10 milligrams had been wasted. In a confidential interview on 2/9/2011 at 1:50 p.m., a nurse indicated the whole tablet of Ambien 10 milligrams had been given. The tablet had not been cut in half nor any part of the tablet wasted. In an interview on 2/9/2011 at 2 p.m., LPN #2 indicated she had broken the tablet and given only 5 milligrams of the			155479				02/10/2	011
NAME OF PROVIDER OR SUPPLIER 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825 IN A RECEIVED OF FORT WAYNE IN46825 IN A RECEIVED OF THE PROPRIET OF			<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ļ	
CALL DESCRIPTION CARE CENTER OF FORT WAYNE FORT WAYNE, IN46825	NAME OF I	PROVIDER OR SUPPLIEF	₹				AD	
RESIDENCE AND COMPLETION DATE A narcotic reconciliation record, dated 12/22/2010, indicated the Ambien supplied to the facility was 10 milligrams. The record indicated Ambien 10 milligrams had been administered on the following dates: December 26, 27, 28, 29, 30, and 31; January 1, 2, 3, and 4. The record indicated half of the Ambien 10 milligram tablet had been wasted on 1/4/2011. A drug disposition record, dated 1/4/2011, indicated half at ablet of Ambien 10 milligrams had been wasted. In a confidential interview on 2/9/2011 at 1:50 p.m., a nurse indicated the whole tablet of Ambien 10 milligrams had been given. The tablet had not been cut in half nor any part of the tablet wasted. In an interview on 2/9/2011 at 2 p.m., LPN #2 indicated she had broken the tablet and given only 5 milligrams of the	KINGST	ON CARE CENTER	R OF FORT WAYNE					
A narcotic reconciliation record, dated 12/22/2010, indicated the Ambien supplied to the facility was 10 milligrams. The record indicated Ambien 10 milligrams had been administered on the record indicated half of the Ambien 10 milligrams had been wasted on 1/4/2011, a drug disposition record, dated 11/4/2011, indicated half a tablet of Ambien 10 milligrams had been wasted. In a confidential interview on 2/9/2011 at 1:50 p.m., a nurse indicated the whole tablet of Ambien 10 milligrams had been cut in half nor any part of the tablet wasted. In an interview on 2/9/2011 at 2 p.m., LPN #2 indicated she had broken the tablet and given only 5 milligrams of the	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
A narcotic reconciliation record, dated 12/22/2010, indicated the Ambien supplied to the facility was 10 milligrams. The record indicated Ambien 10 milligrams had been administered on the following dates: December 26, 27, 28, 29, 30, and 31; January 1, 2, 3, and 4. The record indicated half of the Ambien 10 milligram tablet had been wasted on 1/4/2011. A drug disposition record, dated 1/4/2011, indicated half a tablet of Ambien 10 milligrams had been wasted. In a confidential interview on 2/9/2011 at 1:50 p.m., a nurse indicated the whole tablet of Ambien 10 milligrams had been cut in half nor any part of the tablet wasted. In an interview on 2/9/2011 at 2 p.m., LPN #2 indicated she had broken the tablet and given only 5 milligrams of the						CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
A narcotic reconciliation record, dated 12/22/2010, indicated the Ambien supplied to the facility was 10 milligrams. The record indicated Ambien 10 milligrams had been administered on the following dates: December 26, 27, 28, 29, 30, and 31; January 1, 2, 3, and 4. The record indicated half of the Ambien 10 milligram tablet had been wasted on 1/4/2011. A drug disposition record, dated 1/4/2011, indicated half a tablet of Ambien 10 milligrams had been wasted. In a confidential interview on 2/9/2011 at 1:50 p.m., a nurse indicated the whole tablet of Ambien 10 milligrams had been cut in half nor any part of the tablet wasted. In an interview on 2/9/2011 at 2 p.m., LPN #2 indicated she had broken the tablet and given only 5 milligrams of the	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
10 milligram tablet, but had failed to complete documentation regarding destruction of the half of the tablet not given. 3. Resident #55's clinical record was reviewed on 2/7/2011 at 2:30 p.m. Resident #55's diagnoses included but were not limited to high blood pressure, depression and anxiety. 3. Resident #55's diagnoses included to complete documentation regarding oxygen storage room (400 Hall) Only oxygen equipment in use will be stored in the resident's room. CONTACTS FOR QUESTIONS: Carrie Lukins RN, Director of Nursing POLICY REPLACED: (Enter filename of policy replaced or revised, or "New Policy") ISSUED BY: Carrie Lukins RN, Director of Nursing ISSUED DATE: LAST DATE OF REVISION: 2/2011 FACILITY		A narcotic recon 12/22/2010, indisupplied to the firm the record indicated milligrams had be following dates: 29, 30, and 31; Ji record indicated milligram tablet 1/4/2011. A drug 1/4/2011, indicated milligram tablet 1/4/2011, indicated milligram tablet 1/50 p.m., a nurstablet of Ambien 10 milligram. The tablet nor any part of the In an interview of LPN #2 indicated tablet and given 10 milligram tablet complete docum destruction of the given. 3. Resident #55's divere not limited.	aciliation record, dated cated the Ambien facility was 10 milligrams. Fated Ambien 10 peen administered on the December 26, 27, 28, anuary 1, 2, 3, and 4. The half of the Ambien 10 had been wasted on a disposition record, dated ted half a tablet of grams had been wasted. Interview on 2/9/2011 at see indicated the whole in 10 milligrams had been thad not been cut in half the tablet wasted. In 2/9/2011 at 2 p.m., in dishe had broken the only 5 milligrams of the olet, but had failed to the entation regarding the half of the tablet not in the control of the control			orders will have oxygen satural levels monitored every shift a as needed for signs and symptoms of respiratory distrators to evaluate need for treatment Residents with oxygen will have an active physician order direct appropriate liter flow, device, duration, and reason. 4. In the event of emergency oxygen in be administered without a physicians order as a nursing measure and an order for oxywill be obtained by the physician enext business day. 5. Non-licensed staff may transfoxygen equipment (i.e. concentrator to portable tank) set physician ordered flow rate. Concentrator to portable tank) set physician ordered flow rate. Oxygen tubing will be charper Kingston Healthcare polica. Oxygen in use signs will be posted on outside and inside door frames, latch side, where oxygen is in use. 9. Oxygen to be stored only in appropriate oxygen storage room (400 Have Only oxygen equipment in use to be stored in the resident's rook CONTACTS FOR QUESTION Carrie Lukins RN, Director on Nursing POLICY REPLACED (Enter filename of policy replaced or revised, or "New Policy") ISSUED BY: Carrie Lukins RDirector of Nursing ISSUED DATE: LAST DATE OF	ation nd ess t. 3. ve cting ne nay gen ian er and e. t flow. nged y. e will e will om. IS: f D: aced	

000522

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE : COMPL		
		155479		LDING		02/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON CENTER ROA	D	
KINGST	ON CARE CENTER	OF FORT WAYNE		1	WAYNE, IN46825	ט	
	_	TATEMENT OF DEFICIENCIES		ID	<u> </u>		(V5)
(X4) ID PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	REGULATORTOR	LEGE IDENTIFIEND IN ORWINTION)	+	1710	NAME: Kingston Care Center	of	DATE
		1 1 1 1 1 1 0 1 0 0 1 0 0 1 0			Fort Wayne POLICY : To assu		
	1	der, dated 10/20/2010,			resident's scheduled for		
		nurse at 1:50 p.m.			laboratory and/or diagnostic		
	indicated Reside	nt #55 needed repeat			services are completed and		
	chest x-ray in 2 v	weeks.			necessary treatment is		
					obtained. PROCEDURE:		
	A review of Res	ident #55's Medication			Laboratory Orders 1. Lab		
		Record, dated October			orders received will be noted i		
		he chest x-ray was to be			lab/diagnostic tracker book on		
		•			month log when test due. 2. It lab requisition will be complete		
completed on 11-2-2010. The Medication					and faxed to the lab with	,u	
Administration Record, dated 11-10, did					scheduled draw date 3. Lab		
not indicate a chest x-ray was to be					requisition white copy to be file	ed	
	completed or that one had been				in lab book behind monthly log		
	completed.				4. Lab requisition <u>yellow</u> copy		
					be filed in medical record unde		
	A review of Res	ident #55's record			lab tab in medical record. 5. L	ab	
		x-ray, dated 2/05/2011,			test to be written on nursing calendar on scheduled due da	to	
	but did not inclu				(long term care unit only). 6.	ic	
		-			When lab specimen obtained		
	_	een 10/20/2010 and			make note in MAR. 7. When I	ab	
	2/05/2011.				results obtained highlight		
					scheduled lab, previously		
	A review of the	nurse's notes between			documented when order		
	10/20/2010 and 2	2/6/2011 did not indicate			obtained, on monthly lab track log and initial. 8. Forward Lab	-	
	a chest x-ray had	l been completed.			results to physician or physicia		
		_			extender for follow up.	•••	
	In an interview of	on 2/09/2011 at 8:50 a.m.,			Diagnostic Tests Orders 1.		
		d when an order is			Diagnostic test orders will be		
		est x-ray, the order is			noted in lab/diagnostic tracker		
					book on month log when test	due.	
		y company and the x-ray			Notify transportation	205	
	is scheduled.				department if diagnostic service not available at facility. 3. Cal		
					Diagnostic service provider an		
	In an interview of	on 2/09/2011 at 8:55 a.m.,			place order for diagnostic test.		
	the Director of N	Jursing indicated the			Document order number on		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2011	
	PROVIDER OR SUPPLIER	OF FORT WAYNE	STREET 1010 V	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON CENTER ROAWAYNE, IN46825	AD
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE
	chest x-ray had nordered.	not been completed as		physician order. 5. Diagnosti test to be written on nursing calendar on scheduled due di (long term care unit only). 6. When Diagnostic test comple make note in MAR. 7. When Diagnostic test completed highlight scheduled test, previously documented when order obtained, on monthly lab/diagnostic tracking log an initial. 8. Forward Diagnostic results to physician or physici extender for follow up. CONTACTS FOR QUESTIONS: Carrie Lukins RN, Director of Nursing POLICY REPLACED: (Enter filename of policy replaced or revised, or "New Policy") ISSI BY: Carrie Lukins RN, Director of Nursing ISSUED DATE: LAST DATE OF REVISION: 2/2011	ate ted d test an

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DING		COMPLE	ETED
		155479	A. BUII B. WIN			02/10/20)11
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			/ WASHINGTON CENTER ROA	VD.	
KINGSTO	ON CADE CENTED	OF FORT WAYNE			WASHINGTON CENTER ROP WAYNE, IN46825	ND	
	ON CARE CENTER	OF FORT WATNE	_	FORT			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	4. Review of the	clinical record of	F02	82	Resident #66 oxygen order ha	as	03/11/2011
	Resident #41 on	2/7/11 at 11:10 a.m.,			been clarified and is being administered as ordered as of	.	
	indicated the foll	lowing: diagnoses			2/8/2011. Residents receiving		
	included, but we	re not limited to.			oxygen have been audited and		
	•	disease and gout.			verified administration as	_	
	octooro vascarar	ansease and gout.			ordered. Licensed nursing sta	aff	
	A aummant mhrisis	ion order for Desident			will be educated on Oxygen		
	A current physician order for Resident #41, dated 2/7/11, indicated she was to receive Allopurinol 100 mg (milligrams) daily for gout. Facility Nurse's Notes for Resident #41,				administration policy and		
					procedure and following		
					physician's orders by March 1	1,	
					2011. Random audits will be completed to check oxygen		
					administration daily for 7 days		
					weekly for 3 months and month		
	dated 12/21/10, indicated "writer rec'd				for 3 months by the Clinical		
	(received) phone call from				Directors and/or designee.		
	`	ter requests res (resident)			Results from audits will be		
	_				corrected and educated as		
		r for sore L (left) large			needed with results brought		
		ite note for NP (Nurse			monthly to facility Continuous Quality Improvement meeting.		
	Practitioner) to s	ee her"			Resident #53 medication has	.	
					been audited and is receiving	the	
	A facility Progre	ss Notes for Resident			correct dose of medication.		
	#41, dated 12/22	/10, indicated she was			Controlled medications will be		
		e Practitioner for her left			audited to verify current		
	· ·	The Progress Notes also			medication order matches cur		
		nt #41 had a history of			supply and narcotic count she	et.	
		•			Licensed nursing staff will be educated on medication		
	gout. The Progre				administration, documentation	,	
	indicated a uric a	acid level was ordered.			and drug disposition of control		
					substances policy and		
		er for Resident #41, dated			procedures by March 11, 201	1.	
	12/22/10, indicat	ted a uric acid level on			Random audits of administrati	on	
	12/24/10 due to 1	left great toe pain.			and documentation will be		
					completed weekly for 1 month		
	 Facility Nurse's 1	Notes for Resident #41,			every two weeks for 2 months and monthly for 3 months by t		
	-	indicated a new order was			Clinical Directors, and/or	110	
		indicated a new order was			Snoai Birottoro, aria/or		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4VNL11

Facility ID:

000522

If continuation sheet

Page 8 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED	
		155479	B. WIN			02/10/20	011
NAME OF I	DROVIDED OD GLIDDI IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1010 W	WASHINGTON CENTER ROA	ر.D	
	ON CARE CENTER			<u>.</u>	WAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	 	ic acid level on 12/24/10.	-	TAG	designee. Results from audits		DATE
	The Director of Nursing (DON) was interviewed on 2/9/11 at 8:55 a.m. During the interview, she indicated a uric acid level was ordered for Resident #41,				will be reviewed and education done as needed with results brought monthly to facility Continuous Quality Improvement meeting. Residents #55 has had		
	1				a chest x-ray completed on		
	but not drawn. She also indicated the lab				2/5/2011. Resident #41 has hat follow up lab tests completed of		
	had been contact	ed determining the lab			2/8/2011 with no new orders.		
		the order for the uric			Residents with laboratory and	l/or	
	acid.				diagnostic orders have been		
				audited for follow through of physician orders. Licensed			
	A facility policy	on following physician's			nursing staff will be educated	on	
	orders was requested on 2/9/11 at 3:30				laboratory and diagnostic police		
	p.m. during the e				and procedures by March 11,		
					2011. Random audits of laboratory and diagnostic		
	The DON was in	iterviewed on 2/10/11 at			physician's orders will be		
	1:34 p.m. Durin	g the interview, she			completed daily for 1 month,		
	indicated the onl	y policy the facility had			every two weeks for 2 months		
	on following phy	vsician orders described			and monthly for 3 months by the Clinical Directors and/or	ne	
	the procedure nu	rsing staff were to follow			designee. Results from audits	,	
	1 ^	recording physician			will be corrected and educated		
	1	indicated physician			needed with results brought		
	orders were to be	2 2			monthly to facility Continuous		
					Quality Improvement meeting. FACILITY NAME: Kingston Ca	are	
	3.1-35(g)(2)				Center of Fort Wayne POLICY		
	(6)(-)				To assure resident's receiving		
					oxygen therapy are monitored		
					effectiveness of treatment and	/or	
					need for changes in treatment. PROCEDURE: 1.		
					Residents on oxygen will have	,	
					oxygen saturation levels		
					monitored every shift and as		
					needed for signs and sympton	ns	
					of respiratory distress. 2.		

PRINTED: 03/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155479			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2011	
	ROVIDER OR SUPPLIEI DN CARE CENTER	R OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TTATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
				Residents with as needed or orders will have oxygen satulevels monitored every shift as needed for signs and symptoms of respiratory distorevaluate need for treatmer Residents with oxygen will han active physician order dirappropriate liter flow, device duration, and reason. 4. In event of emergency oxygen be administered without a physicians order as a nursing measure and an order for oxygen be obtained by the physicians order as a nursing measure and an order for oxygen equipment (i.e., concentrator to portable tanks to physician ordered flow responsible to the physician ordered flow responsible to the per Kingston Healthcare pol 8. Oxygen tubing will be chaper Kingston Healthcare pol 8. Oxygen in use signs will posted on outside and inside door frames, latch side, when oxygen is in use. 9. Oxygen be stored only in appropriate oxygen storage room (400 honly oxygen equipment in use stored in the resident's recontracts for QUESTIO Carrie Lukins RN, Director Nursing POLICY REPLACE (Enter filename of policy repor revised, or "New Policy") ISSUED BY: Carrie Lukins Director of Nursing ISSUEI DATE: LAST DATE OF REVISION: 2/2011 FACILIT	tress ent. 3. ave ecting the may gygen ician sfer k) and ate. ot r flow. anged icy. be e of ere in will e dall) se will boom. NS: of ED: laced RN, D	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4VNL11

Facility ID:

000522

If continuation sheet

Page 10 of 17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155479		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2011			
	PROVIDER OR SUPPLIER	OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) NAME: Kingston Care Center Fort Wayne POLICY: To assisted the scheduled for laboratory and/or diagnostic services are completed and necessary treatment is obtained. PROCEDURE: Laboratory Orders 1. Laboratory Orders 1. Laboratory orders tracker book or month log when test due. 2. lab requisition will be completed and faxed to the lab with	in A		
				and faxed to the lab with scheduled draw date 3. Lab requisition white copy to be fi in lab book behind monthly lo 4. Lab requisition yellow cop be filed in medical record und lab tab in medical record. 5. test to be written on nursing calendar on scheduled due d. (long term care unit only). 6. When lab specimen obtained make note in MAR. 7. When results obtained highlight scheduled lab, previously documented when order obtained, on monthly lab trace log and initial. 8. Forward Lar results to physician or physicial extender for follow up. Diagnostic Tests Orders 1. Diagnostic Tests Orders 1. Diagnostic test orders will be noted in lab/diagnostic tracked book on month log when test 2. Notify transportation department if diagnostic servinot available at facility. 3. Ca Diagnostic service provider a place order for diagnostic test Document order number on	g. y to er Lab ate lab king b an r due. ces II		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUL			ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155479	B. WIN			02/10/2	011
		II			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t .		1	WASHINGTON CENTER ROA	ر. D	
		OF FORT WAYNE		FORT V	WAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	physician order. 5. Diagnostic test to be written on nursing calendar on scheduled due da (long term care unit only). 6. When Diagnostic test complet make note in MAR. 7. When Diagnostic test completed highlight scheduled test, previously documented when order obtained, on monthly lab/diagnostic tracking log and initial. 8. Forward Diagnostic results to physician or physicia extender for follow up. CONTACTS FOR QUESTIONS: Carrie Lukins RN, Director of Nursing POLICY REPLACED: (Enter filename of policy replaced or revised, or "New Policy") ISSUBY: Carrie Lukins RN, Direct of Nursing ISSUED DATE: LAST DATE OF REVISION: 2/2011	ed est	DATE
	l .						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
155479		A. BUILDING B. WING		02/10/2011			
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					V WASHINGTON CENTER ROA	'D	
KINGSTON CARE CENTER OF FORT WAYNE					WAYNE, IN46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0329		ew and record review, the	F0329		Resident #53 has been evaluation		03/11/2011
SS=D	facility failed to	ensure gradual dose			and began a dosage reduction on 2/17/2011. Residents receiving		
	reduction or tape	ring was attempted for 1			psychoactive medications will	¹⁹	
	resident of 23 rev	viewed with psychotropic			under go an audit and review	of	
	medication in a to	otal sample of 24.				last dosage reduction attempt and	
	(Resident #53)	•			a tracking tool has been		
	(11051001101101101)				implemented to log last dosag	e	
	Findings include:	a include:		reduction and next schedu			
	Tillulings illetude.	•			dosage reduction. Licensed nursing staff will be educated or	on	
	D 11 . //501				psychoactive medication	OII	
	Resident #53's record was reviewed on 2/07/2011 at 11 a.m. Resident #53's diagnoses included but were not limited to depression, high blood pressure, and diabetes.				administration policy and		
					procedures including but not		
					limited to dosage reduction		
					requirements by March 11, 20	11.	
					Resident's on psychoactive		
					medications will be reviewed monthly at behavior managem	nent	
	A physician's ord	ler, dated 3-16-2010,			meeting by the Clinical Director		
	indicated Ambien 5 milligrams every evening had been ordered.				Nurse Practitioner, Social	,	
					Worker, Consultant Pharmacis		
	Č				and/or designees. Findings w	ill	
	Review of nurse's notes, dated 3-18-2010 through 2-5-2011, did not indicate any insomnia or difficulty sleeping. Review of the Minimum Data Set, dated				be brought monthly to facility Continuous Quality Improvement	ont	
					meeting for review.	CIII	
					Psychoactive Medication		
					Tracking		
					Resident NameRoom		
					NumberDate OrderedName &		
		/27/2011, indicated			Type of Psychoactive DrugDiagnosisDx on Monthy		
		d not have trouble falling			OrdersDate Reduced or		
	or staying asleep	-			discontinuedCare Plan		
	Review of mental and behavioral health				UpdatedDate next scheduled		
					reduction attempt		
	visits conducted	6-17-2010 through					
	11-1-2010 did no	ot indicate Resident #53					
	had any trouble sleeping. There was no						
		reduction or tapering					
		r · U					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155479		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/10/2011		
		155479	B. WIN			02/10/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	Б.	
KINGSTON CARE CENTER OF FORT WAYNE				1	/ WASHINGTON CENTER ROA WAYNE, IN46825	עט	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	had been conside	ered.					
	In an interview of Social Service Stathere was no dochad any problem reduction had not further indicated actively receiving there was no indicated any trouble sleep had not been conformed and the planning team. If necessary, this is recordUnless reductions are att documentedHy dose reduction is within six month	n 2/9/2011 at 9:50 a.m., aff (SS) #1 indicated umentation Resident #53 sleeping and a dose t been considered. SS#1 Resident #53 was g psychiatric care but cation Resident #53 had ing and a dose reduction sidered. entitled psychoactive dated 8/02/2010, he continued need for the dication is reassessed prescriber and the care and continuation is deemed indicated in the medical medically					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
155479		A. BUILDING			02/10/2011		
		100170	B. WIN			02/10/20	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON CENTER ROA	D	
KINGSTON CARE CENTER OF FORT WAYNE				1	WAYNE, IN46825		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0502	Based on intervie	ew and record review, the	F05	02	Resident #68 has had a		03/11/2011
SS=D	facility failed to	ensure labs were obtained			documented CBC drawn on 2/1/2011 with no new orders.		
	as ordered by the	physician for 1 of 24			Residents with laboratory orde	ers	
	residents reviewe	ed for lab results in a total			have been audited for follow		
	sample of 24. (Re	esident #68)			through of physician orders for	·	
		,			the months of Dec, Jan, and		
	Findings include:				February. Licensed nursing st		
	1	•			will be educated on laboratory policy and procedures by Marc		
	Resident #68's re	cord was reviewed			11, 2011. Random audits of	,,,	
					laboratory physician's orders v	vill	
	2/9/2011 at 2:45 p.m. Resident #68's diagnoses included but were not limited to anemia, heart disease, and diabetes.				be completed daily for 1 month		
					every two weeks for 2 months		
					and monthly for 3 months by the	ne	
					Clinical Directors and/or	.	
		ler, dated 1/4/2011,			designee. Results from audits will be corrected and educated		
	indicated Resider	nt #68 was to have a			needed with results brought	1 43	
	Complete blood Count drawn on 1/11/2011.				monthly to facility Continuous		
					Quality Improvement meeting.		
					FACILITY NAME: Kingston Ca		
	Review of the clinical record revealed no results of a complete blood count for or around the date of 1/11/2011. A review of Nurse's notes, dated 1/4/2011				Center of Fort Wayne POLICY		
					To assure resident's schedule for laboratory and/or diagnosti		
					services are completed and	٠	
					necessary treatment is		
					obtained. PROCEDURE:		
		1, did not indicate			Laboratory Orders 1. Lab		
	_				orders received will be noted in		
		I refused to have a			lab/diagnostic tracker book on		
	•	ount drawn nor did the			month log when test due. 2. / lab requisition will be complete		
		e complete blood count			and faxed to the lab with	~	
	had been drawn.				scheduled draw date 3. Lab		
					requisition white copy to be file		
	A laboratory requ	uest form, dated			in lab book behind monthly log		
	1/4/2011, had been sent to the lab to draw				4. Lab requisition <u>yellow</u> copy be filed in medical record under		
	a complete blood	count for Resident #68			lab tab in medical record under		
	on 1/11/2011.				test to be written on nursing		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
155479		A. BUILDING		02/10/2011			
			B. WING	T ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					را.		
KINGSTO	ON CARE CENTER		1010 W WASHINGTON CENTER ROAD FORT WAYNE, IN46825				
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	TE COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	In an interview 2 the Director of N the lab had been drawn. In an interview 2 the Director of N was no specific p	/10/2011 at 9:22 a.m., fursing indicated although ordered, it had not been /10/2011 at 12:25 p.m., fursing indicated there policy regarding obtaining restood labs would be		calendar on scheduled due da (long term care unit only). 6. When lab specimen obtained make note in MAR. 7. When I results obtained highlight scheduled lab, previously documented when order obtained, on monthly lab track log and initial. 8. Forward Lab results to physician or physicia extender for follow up. <i>Diagnostic Tests Orders</i> 1. Diagnostic test orders will be noted in lab/diagnostic tracker book on month log when test of 2. Notify transportation department if diagnostic service not available at facility. 3. Cal Diagnostic service provider an place order for diagnostic test. Document order number on physician order. 5. Diagnostic test to be written on nursing calendar on scheduled due da (long term care unit only). 6. When Diagnostic test completed highlight scheduled test, previously documented when order obtained, on monthly lab/diagnostic tracking log and initial. 8. Forward Diagnostic results to physician or physicia extender for follow up. CONTACTS FOR QUESTIONS: Carrie Lukins RN, Director of Nursing POLICY REPLACED: (Enter filename of policy replaced or	ab ing an due. ces l id 4. ces lete ed		
				revised, or "New Policy") ISSL			

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
155479		B. WING		02/10/2011		
NAME OF I	PROVIDER OR SUPPLIER		I	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON CENTER ROA	AD	
KINGSTO	ON CARE CENTER			WAYNE, IN46825		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	BY: Carrie Lukins RN, Direct of Nursing ISSUED DATE: LAST DATE OF REVISION: 2/2011		